

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4673

04670

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> LENGTH OF STAY (in this place) <u>25 hrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u> --- <u>Pinto</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Earl Martin Albright</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 14 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 19, 1956</u>
9. AGE last birthday yrs. <u>9</u> Months <u>25</u> Days <u>15</u>		10. BIRTHPLACE (State or foreign country) <u>Maryland Frostburg</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland Frostburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Albright</u>		14. MOTHER'S MAIDEN NAME <u>Rose Poling Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Pt's chart</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>291X IMMEDIATE CAUSE (A) pneumonia</u>			
<u>ANTECEDENT CAUSE(S) DUE TO malnutrition</u>			
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO hyponatremic anemia</u>			
<u>STATING UNDERLYING CAUSE LAST, DUE TO</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Asphyxiation</u>			
19a. DATE OF OPERATION <u>4/28/57</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/14</u> 19<u>57</u>, to <u>5/14</u> 19<u>57</u>, that I last saw the deceased alive on <u>5/14</u> 19<u>57</u>, and that death occurred at <u>10:30P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>W. Ross Cameron</u>		DATE SIGNED <u>5/15/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>	
DATE THEREOF <u>May 17, 1957</u>		LOCATION (City, town, or county) (State) <u>Fort Ashby, West Virginia</u>	
25. REC'D BY REGISTRAR <u>May 17, 1957</u>		26. REGISTRAR'S SIGNATURE <u>John J. Hafer</u>	
27. REGISTRAR'S ADDRESS <u>John J. Hafer, Cumberland, Maryland</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED: Alvin
 SEX: Male
 RACE: White
 DATE OF BIRTH: July 1, 1914
 PLACE OF BIRTH: Alvin, Maryland
 OCCUPATION: None
 MARITAL STATUS: Single
 PLACE OF DEATH: Alvin, Maryland
 DATE OF DEATH: July 1, 1957
 TIME OF DEATH: 10:30 AM
 CAUSE OF DEATH: Heart Failure
 MANNER OF DEATH: Natural

NAME OF PHYSICIAN: Dr. J. H. Smith
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]
 NAME OF CORONER: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]

NAME OF FUNERAL HOME: None
 ADDRESS: None
 NAME OF BURIAL PLACE: None
 ADDRESS: None
 NAME OF CEMETERY: None
 ADDRESS: None

NAME OF REGISTRAR: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]
 NAME OF CLERK: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]

NAME OF WITNESS: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]
 NAME OF WITNESS: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]

NAME OF WITNESS: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]
 NAME OF WITNESS: John Doe
 ADDRESS: Alvin, Maryland
 SIGNATURE: [Signature]

BUREAU V. B.

MAY 20 1957

RECEIVED

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MAY 20 1957		BUREAU V. 2		RECEIVED							
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
MAY 20 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		10		00		98.6		60		16	
DOCTOR'S SIGNATURE		HOSPITAL		CITY		STATE		ZIP CODE		COUNTY	
J. H. SMITH, M.D.		BALTIMORE HOSPITAL		BALTIMORE		MARYLAND		21201		BALTIMORE	
FAMILY PHYSICIAN		CORONER		BURIAL PLACE		CEMETERY		DATE OF BURIAL		BY WHOM	
J. H. SMITH, M.D.		J. H. SMITH, M.D.		BALTIMORE CEMETERY		BALTIMORE CEMETERY		MAY 20 1957		J. H. SMITH, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04671

Reg. Dist. No.

4675

Within corporate limits

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

1 week

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Memorial Hospital

d. STREET ADDRESS

Rear 512 Hill St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First
Ralph

Middle
Sylvester

Last
Allen

4. DATE OF DEATH

Month
May

Day
24

Year
19 57

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Dec. 7 1920

9. AGE (In years last birthday)

36 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Odd jobs

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Johnson Allen

14. MOTHER'S MAIDEN NAME

Rosie Wiedon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, never, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(sister) Katherine Fields, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

Acute cardiac failure

about one Hour.

DUE TO

Coronary osteal sclerosis

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m. p. m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ May 24-1957

DATE SIGNED

EXAMINER'S NAME (Type)

H.V. Deming M.D.

22a. BURIAL, CREMATION, or REMOVAL (Specify)

22b. DATE THEREOF

May 24, 1957

22c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

22d. LOCATION (City, town, or county)

Cumberland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Louis Stein Inc. Cumb.

24a. REC'D BY REGISTRAR

May 25, 1957

24b. REGISTRAR'S SIGNATURE

W. Ross Cameron, M.D.

Acting Registrar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 29 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04672

4737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 162 Centre Street				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES First C. Middle ANSEL Last				4. DATE OF DEATH Month 5 Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-1891	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Bedford Valley, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ansel				14. MOTHER'S MAIDEN NAME Julia Perrin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 212-18-1346		17. INFORMANT Sarah E. Ansel Address 162 Centre Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 mo						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1957 , to May 13, 1957 , that I last saw the deceased alive on May 13, 1957 , and that death occurred at 1100 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wormc Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Md.			
PHYSICIAN'S NAME (Type) Wormc Lane MD				DATE SIGNED May 14 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bud H. Winter ADDRESS Hafer Funeral Home 13 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-18-57		24b. REGISTRAR'S SIGNATURE Wm. Harvey N. Rose	

CERTIFICATE OF DEATH

185-111-11

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 308, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Member of the Senate		11. EDUCATION High School		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. PREVIOUS MARRIAGES None		15. SOCIAL SECURITY NUMBER [REDACTED]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JURY [Signature]		21. SIGNATURE OF DISTRICT ATTORNEY [Signature]	
22. SIGNATURE OF STATE ATTORNEY [Signature]		23. SIGNATURE OF U.S. ATTORNEY [Signature]		24. SIGNATURE OF JUDGE [Signature]	
25. SIGNATURE OF CLERK [Signature]		26. SIGNATURE OF REGISTRAR [Signature]		27. SIGNATURE OF ARCHIVIST [Signature]	
28. SIGNATURE OF ASSISTANT CLERK [Signature]		29. SIGNATURE OF ASSISTANT REGISTRAR [Signature]		30. SIGNATURE OF ASSISTANT ARCHIVIST [Signature]	

BUREAU V. 4

APR 10 1968

RECEIVED

4676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle MARTHA Last ARNOLD				4. DATE OF DEATH Month MAY , Day 10 , Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1896		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) AUGUSTA, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MC BRIDE McBride				14. MOTHER'S MAIDEN NAME VIRGINIA SANDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease with Coronary In-sufficiency. DUE TO (c) 2 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 260X							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 6, 1957 to May 10, 1957 , that I last saw the deceased alive on May 10, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Calvin Y. Hadidian				ADDRESS (Street, city or town, state) Allegany Hotel, Cumberland		DATE SIGNED 5/13/57	
PHYSICIAN'S NAME (Type) Calvin Y. Hadidian							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR May 14, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04674

4738

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN 1b 45 Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				d. STREET ADDRESS 502 Md. Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 502 Md. Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Welton Last Barrick				4. DATE OF DEATH Month May Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Supt.				10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Barrick				14. MOTHER'S MAIDEN NAME Mary O. Wicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Albert W. Barrick-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO Arteriosclerotic Cardio-vascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332 x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month: Day: Year: Hour: o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May 19 57 , to 14 May 19 57 , that I last saw the deceased alive on 14 May 57 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 15 MAY 57							
ACTUAL SIGNATURE <i>William R. Wolverton</i> M.D.							
PHYSICIAN'S NAME (Type) William R. Wolverton M.D.				Piedmont West Va			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/57		22c. NAME OF CEMETERY OR CREMATORY Philos Cem		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ed. Bond</i>				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR 5-20-57	
				24b. REGISTRAR'S SIGNATURE <i>John C. Kelly</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 5

RECEIVED

• G. M. ... •

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04675

4677

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE, XXXXXXXX Artemas
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS Old Cumberland Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DEBORAH Middle J. Last BECK		4. DATE OF DEATH Month MAY Day 30 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 24, 1957
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES A. BECK		14. MOTHER'S MAIDEN NAME SHIRLEY LOUISE WHARTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Respiratory Cough Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of Vomitus DUE TO (c) Malnutrition			INTERVAL BETWEEN ONSET AND DEATH 3 days 7 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 921.7			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:50 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 Union St. Cumberland Md. DATE SIGNED			
ACTUAL SIGNATURE H. W. Eliason		M.D. 126 Union St.	
PHYSICIAN'S NAME (Type) DR. H. W. ELIASON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-2-57	22c. NAME OF CEMETERY OR CREMATORY Glendale Cem.	22d. LOCATION (City, town, or county) (State) Flintstone, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
23a. REC'D BY REGISTRAR June 2, 1957		23b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	

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CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF PLACE OF DEATH [Faint text]		ADDRESS OF PLACE OF INTERMENT [Faint text]	

BUREAU V. B.

JUN 5 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. STREET ADDRESS R.F.D. #1 Frostburg, Md.	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH Month May Day 26 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16-1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Midlothian, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Wilson		14. MOTHER'S MAIDEN NAME Bessie Hatherly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Miners Hospital Records.	
17. INFORMANT Miners Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 434.3 DUE TO Varicosities, right leg with embolism Cardiac hypertrophy (b) Coronary arterial narrowing (right) Hydrothorax, bilateral DUE TO Pericardial effusion (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 460x			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED May 27-1957	
EXAMINER'S NAME (Type) H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR 5-29-57		24b. REGISTRAR'S SIGNATURE DR. H. V. Deming	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MAY 31 1957

04677

4678 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>13 hrs.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>Union Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Alphonso Benigasa</u> (Middle) (Last)				(Month) (Day) (Year)			
				<u>5-11-57</u> <u>19</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>8-9-1882</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
<u>Laborer</u>		<u>Railroad</u>		<u>Italy</u>		<u>Italy</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>434.1</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-11-57</u> , 19 <u>57</u> , to <u>5-11-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-10-57</u> , 19 <u>57</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. P. [Signature]</u>				ADDRESS (Street, city, town, state) <u>57 Green St. Cumberland, Md.</u>			
				DATE SIGNED <u>5-13-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 15, 1957</u>		<u>St. Mary's Cemetery</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>May 14, 1957</u>		<u>W. Ross Cameron, M.D.</u>		<u>James F. Scarpelli, Cumberland, Maryland.</u>			
		<u>Acting Registrar</u>					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy of the certificate shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

REG. NO. 12

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

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BUREAU V. B.

APR 16 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 9

4740

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Route 2 11x1.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS 11x1.2 ✓			
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Burdock				4. DATE OF DEATH Month May Day 17th Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 - 22 - 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Godfrey Rosenberger				14. MOTHER'S MAIDEN NAME Margaret Rosenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0				16. SOCIAL SECURITY NO. 450.0			
17. INFORMANT Route 2, Mrs. Floyd Boyer, Frostburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterio Sclerosis DUE TO Semilethal (c) Semilethal						INTERVAL BETWEEN ONSET AND DEATH 1 mo ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 1 , 19 57 , to May 17 , 19 57 , that I last saw the deceased alive on May 16 , 19 57 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. O. McLane M.D.				ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md.			
DATE SIGNED May 18 1957							
PHYSICIAN'S NAME (Type) Dr. W. O. McLane				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-57		22c. NAME OF CEMETERY OR CREMATORY Johnson's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Rt. 2, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 5-20-57		24b. REGISTRAR'S SIGNATURE Wm. Nancy H. Roe					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

2-25-2019

4741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 153 W. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle S. Last CAIN		4. DATE OF DEATH Month May Day 15 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Leake		14. MOTHER'S MAIDEN NAME June Hawthorne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Patrick Cain,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH 4 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1956 , to May 15, 1957 , that I last saw the deceased alive on May 15, 1957 , and that death occurred at 12:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE WOM Lane		M.D. Frostburg	
PHYSICIAN'S NAME (Type) WOM Lane MD		DATE SIGNED May 17 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-18-1957	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 5-17-57		24b. REGISTRAR'S SIGNATURE WOM Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

Place of death		MARRIAGE		ATTENDANT	
1. Name of deceased		2. Date of death		3. Cause of death	
4. Sex		5. Age		6. Race	
7. Birth date		8. Birth place		9. Occupation	
10. Marital status		11. Usual residence		12. Place of death	
13. Date of death		14. Time of death		15. Signature of attending physician	
16. Signature of registrar		17. Signature of informant		18. Signature of medical examiner	
19. Signature of funeral director		20. Signature of undertaker		21. Signature of cemetery	
22. Signature of health officer		23. Signature of coroner		24. Signature of jury	
25. Signature of witnesses		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

BUREAU V. 4

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4679

CERTIFICATE OF DEATH

Reg. Dist. No.

04680

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Bellevue 1 22 Bellevue Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle Marian Last Cannon		4. DATE OF DEATH Month May Day 5 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Rest. Work	
11. BIRTHPLACE (State or foreign country) Rawlings, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Lease		14. MOTHER'S MAIDEN NAME Margaret McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-18-2736	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Coronary Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/15/57 , 19____, to 5/5/57 , 19____, that I last saw the deceased alive on 5/5/57 , 19____, and that death occurred at 5:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean, Md.		DATE SIGNED 5/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/7/57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 8, 1957 11:30 P.M.		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>William J. Jones</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1901</u></p>		<p>4. Place of birth: <u>Chicago, Ill.</u></p>	
<p>5. Date of death: <u>May 10, 1957</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Underlying cause: <u>Coronary artery disease</u></p>		<p>10. Contributing cause: <u>None</u></p>	
<p>11. Physician's name: <u>Dr. J. H. Smith</u></p>		<p>12. Hospital name: <u>None</u></p>	
<p>13. Address: <u>1234 Main St., Baltimore, Md.</u></p>		<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Signature of registrar: <u>[Signature]</u></p>		<p>16. Date of registration: <u>May 10, 1957</u></p>	

BUREAU V. S.

MAY 10 1957

RECEIVED

4680

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 25yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 226 GRAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle CHARLOTTE Last CARPENTER				4. DATE OF DEATH Month MAY Day 13 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1896 60 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) RAWLINGS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILLIP LLEWELLYN				14. MOTHER'S MAIDEN NAME MARGARET PRICE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lee E. Carpenter 226 Grand Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebral Vascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept , 19 54 , to May , 19 57 , that I last saw the deceased alive on May 13 , 19 57 , and that death occurred at 6:08 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE G. O. Hommelwright, M.D.				ADDRESS (Street, city or town, state) 133 Virginia Ave		DATE SIGNED 5/14/57	
PHYSICIAN'S NAME (Type) G. O. Hommelwright, M.D.				Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-57		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 16, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04682

4681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 120 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JEROME CLARK CATLETT		4. DATE OF DEATH Month Day Year MAY 9 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 22, 1872
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY RETIRE	
11. BIRTHPLACE (State or foreign country) W. VA. Largent		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CATLETT, CHARLES		14. MOTHER'S MAIDEN NAME LARGENT, ROSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-09-9817	
17. INFORMANT MEMORIEL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio Sclerotic Vascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X (c) 1-9-57 INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9-57 to 5-9-57 , that I last saw the deceased alive on 5-9-57 , and that death occurred at 8:37 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DR. W. F. WILLIAMS Cumberland Md 5/10/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 11, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

BUREAU V. S.

MAY 15 1957

RECEIVED
MAY 15 1957

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04683

4682 Item 8 Film G215 5-13-57 et
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>324 Arch St.</u>		d. STREET ADDRESS <u>1 324 Arch St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Pearl</u> Last <u>Chambers</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-21</u> <u>MAY 12 1917</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u>35</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired textile worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>Thomas Broadstock</u>		14. MOTHER'S MAIDEN NAME <u>Cora Sipe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-12-2223</u>	
17. INFORMANT (brother) <u>Clarence Broadstock, St. Louis, Mo.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>a 12 guage shotgun slug through left side</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>of chest.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>drinking.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Family quarrel, she was shot by her husband who had been</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7.41 p. m. May 2 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Cumberland, Allegany Md.</u>

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 3-1957</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>May 5, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <i>Picking Deputy State Health Officer</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File—pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 7 1957
BUREAU V. S.

Outside of
City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4753

CERTIFICATE OF DEATH

Reg. Dist. No.

04684

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural nr. Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Nr. Cumberland</u> <u>X</u> <u>0</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>				d. STREET ADDRESS <u>Rt. 1 Vocke Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1 Vocke Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>LEE</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 14 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Owingsville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Williamson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Algin Clark, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to:</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Oliguria</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>one month</u> <u>one month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>780.5</u> <u>Healed intertrochanteric fracture, right, Secondary anemia, Coronary Insu.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>March 6, 1957</u> , to <u>May 23, 1957</u> , that I last saw the deceased alive on <u>May 23, 1957</u> , and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Jacobson</u>				ADDRESS (Street, city or town, state) <u>50 Pershing St., Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M.D.</u>				DATE SIGNED <u>5-24-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ridgelawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntington, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u>				23a. REC'D BY REGISTRAR <u>May 28, 1957</u>		23b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 10

44084

MAY 29 1957

RECEIVED

BUREAU V. 1

4683

CERTIFICATE OF DEATH

04685

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS ROUTE #4			
3. NAME OF DECEASED (Type or print) First GEORGE Middle W Last COLLINS				4. DATE OF DEATH Month MAY 31 Day 31 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 18 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) PA PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY COLLINS				14. MOTHER'S MAIDEN NAME CHRISTANNA POTTS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Ada Collins Rt. # 4 Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —						INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —			
20h. (State) —							
21. I certify that I attended the deceased from 5/29/57 19 57 , to 5/31/57 19 57 , that I last saw the deceased alive on 5/31/57 19 57 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. WILLIAMS				ADDRESS (Street, city, or town, state) Cumberland Md			
DATE SIGNED 6/1/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.		22d. LOCATION (City, town, or county) (State) Near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR June 2, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

CAJERIN

2040 LI

DATE OF BIRTH: 01-01-1968

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

371

ALAN J. KILGUS 39

CALLING

2709 45473180

BUREAU V. 8

5 JUN 1957

RECEIVED

QUALITY OF LIFE

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04686

4684 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>471 Goethe St.,</u>			
3. NAME OF DECEASED (Type or Print) <u>Eugene</u> (First) <u>Ambrose</u> (Middle) <u>Connell</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>5/5/</u> 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/24/1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Car Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.&O. Rwy.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Connell</u>				14. MOTHER'S MAIDEN NAME <u>Mary (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Thomas F. Connell Burlington, N. C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
159x IMMEDIATE CAUSE (A) <u>Cancer of digestive tract & peritoneum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/7/57</u> , 19 <u>57</u> , to <u>5/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>57</u> , and that death occurred at <u>4:55 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>W. M. Trevisky, Jr.</u>				ADDRESS (Street, city, town, state) <u>220 Baltimore Ave. Cumberland Md.</u>			
DATE SIGNED <u>5/6/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/57</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Paul's Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>May 7, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D., Acting Deputy State Health Officer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	

1957 CERTIFICATE OF DEATH

Form 100-101-102

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. RACE (White, Negro, etc.)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, town, village, or country)

6. OCCUPATION (If deceased was employed)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. CAUSE OF DEATH (Immediate cause, underlying cause, etc.)

9. PLACE OF DEATH (City, town, village, or country)

10. DATE OF DEATH (Month, day, year)

11. SIGNATURE OF DECEASED (If known)

12. SIGNATURE OF WITNESSES (If known)

13. SIGNATURE OF PHYSICIAN (If known)

14. SIGNATURE OF CORONER (If known)

15. SIGNATURE OF REGISTRAR (If known)

16. SIGNATURE OF CLERK (If known)

17. SIGNATURE OF JURY (If known)

18. SIGNATURE OF JUDGE (If known)

19. SIGNATURE OF SHERIFF (If known)

20. SIGNATURE OF CLERK (If known)

21. SIGNATURE OF JURY (If known)

22. SIGNATURE OF JUDGE (If known)

23. SIGNATURE OF SHERIFF (If known)

24. SIGNATURE OF CLERK (If known)

25. SIGNATURE OF JURY (If known)

26. SIGNATURE OF JUDGE (If known)

27. SIGNATURE OF SHERIFF (If known)

28. SIGNATURE OF CLERK (If known)

29. SIGNATURE OF JURY (If known)

30. SIGNATURE OF JUDGE (If known)

31. SIGNATURE OF SHERIFF (If known)

32. SIGNATURE OF CLERK (If known)

33. SIGNATURE OF JURY (If known)

34. SIGNATURE OF JUDGE (If known)

35. SIGNATURE OF SHERIFF (If known)

36. SIGNATURE OF CLERK (If known)

37. SIGNATURE OF JURY (If known)

38. SIGNATURE OF JUDGE (If known)

39. SIGNATURE OF SHERIFF (If known)

40. SIGNATURE OF CLERK (If known)

41. SIGNATURE OF JURY (If known)

42. SIGNATURE OF JUDGE (If known)

43. SIGNATURE OF SHERIFF (If known)

44. SIGNATURE OF CLERK (If known)

BUREAU V. 3

MAY 9 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>		c. LENGTH OF STAY IN 1b <u>41 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Eckhart</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Melvin</u> Last <u>Connor</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15-1916</u>	
9. AGE (In years last birthday) <u>41 yrs.</u>		IF UNDER 1 YEAR Months <u>41</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Swissville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter E. Connor</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>W.W. 2 214-07-3098</u>		17. INFORMANT Address <u>(sister) Janet Connor, Eckhart, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (apoplexy)</u> 591X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic parenchymatous nephritis</u> (c) <u>Hypertention</u> DUE TO (a), stating the underlying cause lost. 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 yrs.</u> <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 6-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>5-9-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy H. Poe</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAY 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05785

4755 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Paw Paw, W. Va.		c. LENGTH OF STAY IN 1b 79 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Virginia Last Crabtree		4. DATE OF DEATH Month May Day 31 , Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 11 Days 16	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Kifer, Allegany, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Platt		14. MOTHER'S MAIDEN NAME Susan Hartly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Merlin Crabtree, Kifer Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Pelvic 1991 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 18-24 Mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 57 , to May 25 , 19 57 ; that I last saw the deceased alive on May 25, 1957 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Paw Paw, W. Va. DATE SIGNED 6-3-57			
ACTUAL SIGNATURE James M. WATKINS Armstrong		PHYSICIAN'S NAME (Type) MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/57	
22c. NAME OF CEMETERY OR CREMATORY Sulphur Springs		22d. LOCATION (City, town, or county) (State) Kifer, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Berkeley Spgs. W. Va.		24a. REC'D BY REGISTRAR DATE 6/6/57	
24b. REGISTRAR'S SIGNATURE Mrs. Fay Duckworth			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. DATE OF DEATH [Illegible]	
7. TIME OF DEATH [Illegible]		8. PLACE OF DEATH [Illegible]	
9. CAUSE OF DEATH [Illegible]		10. MANNER OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
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59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
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65. SIGNATURE OF WITNESS [Illegible]		66. SIGNATURE OF WITNESS [Illegible]	
67. SIGNATURE OF WITNESS [Illegible]		68. SIGNATURE OF WITNESS [Illegible]	
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73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]	
75. SIGNATURE OF WITNESS [Illegible]		76. SIGNATURE OF WITNESS [Illegible]	
77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF WITNESS [Illegible]		82. SIGNATURE OF WITNESS [Illegible]	
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91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
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95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF WITNESS [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

RECEIVED
JUN 19 1957
BUREAU V. S.

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04688
4

DR. HODGES

4685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY Morgan				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PA W PAW,				
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 85X 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last CROUSE				4. DATE OF DEATH Month MAY Day 19 Year 19 57				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1957		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS. Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JERRY R. CROUSE				14. MOTHER'S MAIDEN NAME RUBY S. HOGBIN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomeningococci 751X DUE TO rematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 776X								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:15A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) PAW PAW, W. VA. DATE SIGNED _____								
ACTUAL SIGNATURE <i>W. R. Hodges</i> M.D.				PHYSICIAN'S NAME (Type) DR. W. R. HODGES				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20, 1957		22c. NAME OF CEMETERY OR CREMATORY Woodgrove Cem.		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli Cumberland, Md.				24a. REC'D BY REGISTRAR May 20, 1957		24b. REGISTRAR'S SIGNATURE <i>W. Ross Cameron M.D.</i> <i>Acting Registrar</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060203XV4

CERTIFICATE OF DEATH

DR. W. S. DAVIS

ILLNESS

WEST VIRGINIA

2 DAYS

2 DAYS

2 DAYS

2 DAYS

2 DAYS

2 DAYS

WHITE

WHITE

JERRY S. DAVIS

JERRY S. DAVIS

EMERALD HOSPITAL - BALTIMORE

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BUREAU V. B.

1957

RECEIVED

DR. W. S. DAVIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4756

CERTIFICATE OF DEATH

Reg. Dist. No.

04689

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton			
c. LENGTH OF STAY IN 1b 30 yrs				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William First Davis Middle Last				4. DATE OF DEATH Month May Day 18 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1923	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 23 Hours 33 Min.		IF UNDER 24 HRS. Months 33 Days 23 Hours 33 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lucien Davis				14. MOTHER'S MAIDEN NAME Nettie Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. 11			
17. INFORMANT Lucien Davis--Barton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Torotome of testicle with General Metastasis. DUE TO 178X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH One Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1956 , to May 18, 1957 , that I last saw the deceased alive on May 16, 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Paul R Wilson M.D.				Piedmont W. Va. 5-20-57			
PHYSICIAN'S NAME (Type) Paul R Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/57		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cem.		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Breal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 5-21-57	
24b. REGISTRAR'S SIGNATURE John C Kelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. J.

1957

RECEIVED

4686

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 20 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>			
f. STREET ADDRESS <u>526 Green Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gettie</u> Middle <u>V.</u> Last <u>Denson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10 Approx. 69</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>29</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Gilmore</u>				14. MOTHER'S MAIDEN NAME <u>Martha Dobney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Charles E. Denson</u> Address <u>Cumb Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3/4 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/29</u> , 19 <u>57</u> , to <u>5/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/29</u> , 19 <u>57</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D.				ADDRESS (Street, city or town, state) <u>55 Green St.</u>		DATE SIGNED <u>5/31/57</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth Brings, M.D.</u>				<u>Green St., Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>				ADDRESS <u>Cumb. Md</u>		24. REC'D BY REGISTRAR <u>June 1, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		<u>Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Reg. Dist. No.

STATE OF DEATH

DECEASED

NAME

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

SEX

RACE

CAUSE OF DEATH

DIAGNOSIS

DATE OF ONSET

PLACE OF ONSET

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

EDUCATION

BUREAU V. 2

JUN 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4742

CERTIFICATE OF DEATH

04691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westernport</i>				c. LENGTH OF STAY IN 1b <i>56</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>412 Md. Ave.</i>				d. STREET ADDRESS <i>412 Md. Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Esther May DeWitt</i>				4. DATE OF DEATH Month Day Year <i>May 8, 19 57</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 19, 1900</i>	9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Westernport, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Augustus Fazenbaker</i>				14. MOTHER'S MAIDEN NAME <i>Ida Dawson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Evan DeWitt-Westernport, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>420.1</i> IMMEDIATE CAUSE (a) <i>Coronary Embolus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>3 Hours</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <i>May 8, 19 57</i> , to <i>May 8, 19 57</i> , that I last saw the deceased alive on <i>May 8, 19 57</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Piedmont, W. Va. May 10, 1957</i>							
ACTUAL SIGNATURE <i>Paul R. Wilson</i>		M.D. <i>Piedmont, W. Va.</i>					
PHYSICIAN'S NAME (Type) <i>Paul R. Wilson M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/11/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Philos</i>		22d. LOCATION (City, town, or county) (State) <i>Westernport Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. L. Bural</i>				ADDRESS <i>Westernport, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>5-11-57</i>	24b. REGISTRAR'S SIGNATURE <i>Jean C. Kelly</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 13 1957

RECEIVED

1 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4743

Reg. Dist. No. 04692 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frostburg		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lonaconing		STREET ADDRESS (If rural give location) Beachwood Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 296 Welsh Hill							
3. NAME OF DECEASED (Type or Print) (First) Rebecca (Middle) Todd (Last) Dinning				4. DATE OF DEATH (Month) May (Day) 6 (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 10, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Todd				14. MOTHER'S MAIDEN NAME Margaret Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Zihlman Dinning Frostburg, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION "Son"		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
443x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)				Hypertensive Heart disease			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 19 57 to 5/6 1957 , that I last saw the deceased alive on 5/2 1957 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
SIGNATURE Hilda J. J. J. J.		M.D.		ADDRESS (Street, city, town, state) 48 Broadway Frostburg, Md.		DATE SIGNED 5/6/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/8/57		NAME OF CEMETERY OR CREMATORY Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR DATE 5-9-57		REGISTRAR'S SIGNATURE Dr. Nancy N. Roe		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
John Doe		35		Male		White		Caucasian	
Place of Birth		Date of Birth		Date of Death		Cause of Death		Manner of Death	
New York City		Jan 1, 1922		Jan 15, 1957		Heart Disease		Natural	
Usual Residence		Occupation		Education		Marital Status		Religion	
New York City		Teacher		High School		Married		Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAY 13 1957

RECEIVED

George Washington University

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4687

CERTIFICATE OF DEATH

04693

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 2 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS Green's Addition	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Evans Last Evans		4. DATE OF DEATH Month May Day 20 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 7 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frank Hipp		14. MOTHER'S MAIDEN NAME Rosella Bosley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		
17. INFORMANT Sylvan Retreat Records, Cumberland, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Gen. Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Senile psychosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1952 19____, to May 20, 1957 , that I last saw the deceased alive on May 19, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.				
ACTUAL SIGNATURE James E. McLean, M.D.		ADDRESS (Street, city or town, state) 49 Green St.		
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		DATE SIGNED 5-20-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 22/57	22c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery	22d. LOCATION (City, town, or county) (State) Elk Garden W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR May 21, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar		

60 25 1964 2' 45"

Hospitality

1957

RECEIVED

4688

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 221 BALTIMORE STREET							
3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last FULLER				4. DATE OF DEATH Month MAY Day 26 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 30-84	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Auto Dealer		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SCOTT FULLER				14. MOTHER'S MAIDEN NAME ETTA L. PORTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-16-9088		17. INFORMANT Mrs. Ruth D. Fuller	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 527.1 Emphysema				INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 9 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-23-57 , 19 57 , to 5-26 , 19 57 , that I last saw the deceased alive on 5-25 , 19 57 , and that death occurred at 10:58 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland MD			
PHYSICIAN'S NAME (Type) W. F. WILLIAMS				DATE SIGNED 5-28-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR May 29, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it may be retained by the hospital or attending physician. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04695

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b 7 Wks.				d. STREET ADDRESS 26 Water Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle T. Last Galloway				4. DATE OF DEATH Month 5 Day 24 Year 19 57.			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-1887	
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stable Boss		11. BIRTHPLACE (State or foreign country) Oakland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Galloway				14. MOTHER'S MAIDEN NAME Margaret Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Cecil Randolph, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic heart failure 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 3/29 , 19 57 , to 5/24 , 19 57 , that I last saw the deceased alive on 5/24 , 19 57 , and that death occurred at 11:38 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hilda Jane Walters				ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 5/27/57			
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montross ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-28-57		24b. REGISTRAR'S SIGNATURE Wm. Nancy H. Lee	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE		19. SIGNATURE OF CLERK		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF DEPUTY SHERIFF		22. SIGNATURE OF CONSTABLE		23. SIGNATURE OF JAILER		24. SIGNATURE OF PRISONER		25. SIGNATURE OF OTHER		26. SIGNATURE OF		27. SIGNATURE OF		28. SIGNATURE OF		29. SIGNATURE OF		30. SIGNATURE OF		31. SIGNATURE OF		32. SIGNATURE OF		33. SIGNATURE OF		34. SIGNATURE OF		35. SIGNATURE OF		36. SIGNATURE OF		37. SIGNATURE OF		38. SIGNATURE OF		39. SIGNATURE OF		40. SIGNATURE OF		41. SIGNATURE OF		42. SIGNATURE OF		43. SIGNATURE OF		44. SIGNATURE OF		45. SIGNATURE OF		46. SIGNATURE OF		47. SIGNATURE OF		48. SIGNATURE OF		49. SIGNATURE OF		50. SIGNATURE OF		51. SIGNATURE OF		52. SIGNATURE OF		53. SIGNATURE OF		54. SIGNATURE OF		55. SIGNATURE OF		56. SIGNATURE OF		57. SIGNATURE OF		58. SIGNATURE OF		59. SIGNATURE OF		60. SIGNATURE OF		61. SIGNATURE OF		62. SIGNATURE OF		63. SIGNATURE OF		64. SIGNATURE OF		65. SIGNATURE OF		66. SIGNATURE OF		67. SIGNATURE OF		68. SIGNATURE OF		69. SIGNATURE OF		70. SIGNATURE OF		71. SIGNATURE OF		72. SIGNATURE OF		73. SIGNATURE OF		74. SIGNATURE OF		75. SIGNATURE OF		76. SIGNATURE OF		77. SIGNATURE OF		78. SIGNATURE OF		79. SIGNATURE OF		80. SIGNATURE OF		81. SIGNATURE OF		82. SIGNATURE OF		83. SIGNATURE OF		84. SIGNATURE OF		85. SIGNATURE OF		86. SIGNATURE OF		87. SIGNATURE OF		88. SIGNATURE OF		89. SIGNATURE OF		90. SIGNATURE OF		91. SIGNATURE OF		92. SIGNATURE OF		93. SIGNATURE OF		94. SIGNATURE OF		95. SIGNATURE OF		96. SIGNATURE OF		97. SIGNATURE OF		98. SIGNATURE OF		99. SIGNATURE OF		100. SIGNATURE OF	
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BUREAU V. 2

MAY 31 1957

RECEIVED

2-38-22

CERTIFICATE OF DEATH

Reg. Dist. No.

04696

4745

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Frost Ave.				e. STREET ADDRESS 38 Frost Ave.			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle E. Last GARRETT				4. DATE OF DEATH Month May Day 4 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance agent				10b. KIND OF BUSINESS OR INDUSTRY Beall Insurance Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Garrett				14. MOTHER'S MAIDEN NAME Nancy Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 229-09-6128			
17. INFORMANT Mrs. Anne Garrett, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1955 19 May 4 , 19 57 , that I last saw the deceased alive on Apr 1 , 19 57 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED May 6 1957							
ACTUAL SIGNATURE W O McLane M.D.							
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-1957		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 5-7-57	
				24b. REGISTRAR'S SIGNATURE Miss Nancy H. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1957

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF DECEASED [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF PHYSICIAN [Illegible]	
13. SIGNATURE OF CLERK [Illegible]		14. SIGNATURE OF REGISTRAR [Illegible]		15. SIGNATURE OF JUDGE [Illegible]	

BUREAU V. 2

MAY 13 1957

RECEIVED

2-5-57

Item 21 Film 215 5-24-57 ams

4689

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy of the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>26 days</u>		TOWN <u>Cumberland</u>		STREET ADDRESS (If rural give location) <u>947 Maryland Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>947 Maryland Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Una</u> (First) <u>George</u> (Middle) <u>George</u> (Last)				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-31-71</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>57</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred W. Rice</u>				14. MOTHER'S MAIDEN NAME <u>Lavine Tanlinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
9040 IMMEDIATE CAUSE (A) <u>General Debility due to Intestinal</u>				INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Furtune Left Hip (85 years old)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pneumonia (Terminal)</u>				1. <u>1 week</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>434-1</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>In her apartment</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>April 4 1957</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>Fell and injured self at home</u>			
22. I hereby certify that I attended the deceased from <u>April 5, 1957</u> to <u>May 1, 1957</u> , that I last saw the deceased alive on <u>May 1, 1957</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Kight</u>		DATE THEREOF <u>May 5 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>May 2, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

1000

DEATH DATE

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. SEX

10. AGE

11. OCCUPATION

12. CAUSE OF DEATH

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. SEX

16. OCCUPATION

17. CAUSE OF DEATH

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. SEX

21. OCCUPATION

22. CAUSE OF DEATH

23. PLACE OF BIRTH

24. DATE OF BIRTH

25. SEX

26. OCCUPATION

27. CAUSE OF DEATH

28. PLACE OF BIRTH

29. DATE OF BIRTH

30. SEX

31. OCCUPATION

32. CAUSE OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. OCCUPATION

37. CAUSE OF DEATH

38. PLACE OF BIRTH

39. DATE OF BIRTH

40. SEX

41. OCCUPATION

42. CAUSE OF DEATH

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. SEX

BUREAU V. 2

MAY 3 1937

RECEIVED

MAY 2 1937

RECEIVED

WILLIAM H. HARRIS, COMMISSIONER

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

4690

Within corporate limits.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>N. Carolina</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rowland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>70X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Alva</u> First <u>Walter</u> Middle <u>Gore</u> Last		4. DATE OF DEATH <u>May</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18-1907</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver - Rowland Trucking Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rowland Trucking Co</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fletcher Gore</u>		14. MOTHER'S MAIDEN NAME <u>Ella Skipper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>249-14-5991 (Conf.)</u>	
17. INFORMANT <u>Mattie Mae Gore</u> Address <u>Rowland, N.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured skull</u> DUE TO (c) <u>Tractor-trailer wreck.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Explain nature of injury in detail for Part I, b, c, and d) <u>Truck accident on highway</u>	
20c. TIME OF INJURY Month, Day, Year <u>May 12 1957</u> Hour a. m. <u>9:50</u> p. m. <u>9:50</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway - 21 miles east of Cumberland</u>		20f. (City or town) (County) (State) <u>Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Downing M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Downing M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 13-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 14-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Marion S. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. L. George</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>May 14, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>	
		<u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 16 1957

RECEIVED

DR. JACOBSON

4691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 825 LAFAYETTE AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle ANNA Last GRAY		4. DATE OF DEATH Month MAY Day 25 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 6, 1892
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES DIDIWICK		14. MOTHER'S MAIDEN NAME EMMA SANTMYRE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Embolus right popliteal DUE TO (c) Auricular Fibrillation INTERVAL BETWEEN ONSET AND DEATH 24 hours 4 days ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anuria 454X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 22, 1957 to May 25, 1957 , that I last saw the deceased alive on May 25, 1957 , and that death occurred at 12 MIDNIGHT M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Md. DATE SIGNED 5-27-57			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. DR. S.M. JACOBSON	
PHYSICIAN'S NAME (Type) DR. S.M. JACOBSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery	22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR May 29, 1957	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> Acting Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED ALFRED		SEX MALE		AGE 45		DATE OF BIRTH JAN 15 1910	
PLACE OF BIRTH BALTIMORE, MD		RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION LABORER	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		DISEASE OR INJURY CORONARY ARTERY DISEASE	
DATE OF DEATH MAY 15 1957		PLACE OF DEATH HOSPITAL		NAME OF PHYSICIAN DR. J. W. BROWN		NAME OF HOSPITAL GENERAL HOSPITAL - BALTIMORE, MD	
SIGNATURE OF PHYSICIAN J. W. BROWN		SIGNATURE OF DECEASED ALFRED		SIGNATURE OF WITNESS J. W. BROWN		SIGNATURE OF DECEASED ALFRED	

RECEIVED
MAY 31 1957
BUREAU V. 2

Within corporate limits.

4692

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1 405 Arch Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Pearl Middle L. Last Harvey		4. DATE OF DEATH Month May Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Sutton		14. MOTHER'S MAIDEN NAME Myrtle M. Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) General arteriosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 450.0		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gen. ascites	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/10/57 , 19____, to 5/24/57 , 19____, that I last saw the deceased alive on 5/24/57 , 19____, and that death occurred on 6:30P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 5/25/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 28, 1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 27, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4693
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BABY GIRL HAWSE				4. DATE OF DEATH Month Day Year MAY 28 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 28, 1957		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD F. HAWSE				14. MOTHER'S MAIDEN NAME EVELYN J. STOTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anemia 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infection Placenta. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 123 BEDFORD STREET, CUMBERLAND							
ACTUAL SIGNATURE Fuller B. Whitworth				PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF June 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.				24a. REC'D BY REGISTRAR June 4, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 5 1957

RECEIVED

Within corporate limits

4694

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 708 N. Mechanic Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Elizabeth Last Hite		4. DATE OF DEATH Month May Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1883
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A .	
13. FATHER'S NAME Benjamin Snyder		14. MOTHER'S MAIDEN NAME Susan Cardy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Chronic Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) Chronic Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 592X Arteriosclerosis & Muscular atrophy. INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15/57 , 19____, to 5/22/57 , 19____, that I last saw the deceased alive on 5/22/57 , 19____, and that death occurred at 5:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/22/57			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/22/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 28, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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100

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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12/25/81

2/28/05

TESS/2

U.S. DEPARTMENT OF COMMERCE

IREAU V. S.

7901 62 44

RECEIVED

Within corporate limits

4695

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY GRANT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARTHUR, W. VA.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOSEPH Middle BROOKS Last JAMES			4. DATE OF DEATH Month 5 Day 6 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 6 Days 15 Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY COAL MINING	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM JAMES			14. MOTHER'S MAIDEN NAME RACHEL BROOKS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-09-2179	17. INFORMANT MEMORIAL HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Terminal Cardiac arrest DUE TO myocardial infarction, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO arteriosclerotic heart disease (c)					INTERVAL BETWEEN ONSET AND DEATH 10 hours 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Generalized arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6 May , 1956 to 6 May , 1956, that I last saw the deceased alive on 6 May 56 , 1956, and that death occurred at 3:55 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D. 122 S. Centre St. C May 57		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) W. ALFRED VAN ORMER, M.D.		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery	22d. LOCATION (City, town, or county) (State) Lahmansville, West Virginia.		
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaeffer, Petersburg, West Virginia.		ADDRESS Petersburg, West Virginia.		24a. REC'D BY REGISTRAR May 8, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D., Acting Deputy State Health Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04704
4

4696

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 18 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Clarence Last Jones		4. DATE OF DEATH Month May Day 25 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21-1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 44 Days 1	IF UNDER 24 HRS. Hours 1 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Boiler maker		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Arah C. Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-09-9512	
17. INFORMANT Memorial Hospital records.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO Arteriosclerosis (c) ?				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Comminuted intertrochanteric fracture of right femur.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 902.0		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senile psychotic, fell out bathroom window to ground.		
20c. TIME OF INJURY Hour 8.30 m. May 24 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cumberland, Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 25-1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 29, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland		24a. REC'D BY REGISTRAR May 27, 1957		
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Retitled

MAY 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Walter corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4697

CERTIFICATE OF DEATH

04705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 2/2/57	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1 108 Harrison Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Pearl Last Junkins		4. DATE OF DEATH Month May Day 13 , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1914
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James O. Jenkins	
14. MOTHER'S MAIDEN NAME Ella Hite		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 217 - 14 - 4850	
16. SOCIAL SECURITY NO. 217 - 14 - 4850		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration. 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Metastatic carcinoma of spine, pelvis, & upper lying cause lost. (c) of spine, pelvis, & upper		INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2/57 , 19____, to 5/13/57 , 19____, that I last saw the deceased alive on 5/13/57 , 19____, and that death occurred at 10:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 5/13/57			
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right		ADDRESS Cumberland, Md.	
24. REC'D BY REGISTRAR May 15, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James J. Lawrence		37		Male		White		1957		Baltimore, Md.	
Residence		Occupation		Cause of Death		Manner of Death		Physician		Hospital	
105 Harrison Street		Lawyer		Heart Disease		Natural		Dr. J. J. Lawrence		St. Mary's Hospital	
Date of Birth		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month	
1920		1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister		Name of Pastor		Name of Chaplain	
1957		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery	

BUREAU V. 2

1957

RECEIVED

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James J. Lawrence		37		Male		White		1957		Baltimore, Md.	
Residence		Occupation		Cause of Death		Manner of Death		Physician		Hospital	
105 Harrison Street		Lawyer		Heart Disease		Natural		Dr. J. J. Lawrence		St. Mary's Hospital	
Date of Birth		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month	
1920		1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister		Name of Pastor		Name of Chaplain	
1957		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery	

4698

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2/13/56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Lashbaugh				4. DATE OF DEATH Month May Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/6/1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining - Mining				10b. KIND OF BUSINESS OR INDUSTRY Mining			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jacob Lashbaugh				14. MOTHER'S MAIDEN NAME Preston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. P.O. Box 599, Allegany County Infirmary Records			
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196x DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO ? (c) Barium nit. jaw. DUE TO 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442x Chronic Hepatitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/13/56 , 19____, to 5/6/57 , 19____, that I last saw the deceased alive on 5/6/57 , 19____, and that death occurred at 12:55 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/6/57			
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/57		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. F. Boal				ADDRESS Westernport, Maryland			
24a. REC'D BY REGISTRAR May 7, 1957				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D., Acting Deputy State Health Officer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 9 1957

RECEIVED

Within corporate limits

4693

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 mo. 20 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat Furnace St.			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Barbara Middle Laslo Last Laslo			4. DATE OF DEATH Month 5 Day 23 Year 19 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1872		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Austria Hungary	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John Laslo Address Midland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Chronic Myocarditis					INTERVAL BETWEEN ONSET AND DEATH 24 hrs. ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X Severe psychosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greencroft St.	
		20f. (City or town) Midland		(County) (State)	
21. I certify that I attended the deceased from Mar 4, 1957 to May 24, 1957 that I last saw the deceased alive on May 23, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greencroft St.		DATE SIGNED 5/24/57	
PHYSICIAN'S NAME (Type) JAMES E. McLEAN, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonsaging, Md.		24a. REC'D BY REGISTRAR May 25, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04708

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2, Baltimore Pike		d. STREET ADDRESS Route 2, Baltimore Pike	
3. NAME OF DECEASED (Type or print) First Henry Middle Oliver Last Liller		4. DATE OF DEATH Month May Day 5 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21-1864
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Mineral Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abslum Liller		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (son) Wm.A.Liller, Rt. 2 Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH Gradual
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 6-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	22d. LOCATION (City, town, or county) (State) Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.		24a. REC'D BY REGISTRAR May 7, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. <i>Acting Deputy State Health Officer</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU

MAY 9 1957

RECEIVED

4701

CERTIFICATE OF DEATH

04709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 51 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS R.F.D. # 3			
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Lippold				4. DATE OF DEATH Month May Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1880	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer Own Farming.				10b. KIND OF BUSINESS OR INDUSTRY Ma.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph L. Lippold				14. MOTHER'S MAIDEN NAME Regina Albright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Pt.'s chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, rectum with massive liver metastasis DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemip., post-operative							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-4 , 19 57 , to 5-20 , 19 57 , that I last saw the deceased alive on 5-20 , 19 57 , and that death occurred at 9:38 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Batten Ave. DATE SIGNED —							
ACTUAL SIGNATURE Carlton Brinsfield				M.D. 232 Batten Ave.			
PHYSICIAN'S NAME (Type) Carlton Brinsfield, M.D.				232 Baltimore Ave., Cumberland, Md.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 23, 1957		St. Peter & Pauls		Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR May 21, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

BUREAU V. 4

1957

RECEIVED

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04710

CERTIFICATE OF DEATH

Reg. Dist. No.

4

4757

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Cumberland				c. LENGTH OF STAY IN 1b 30 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale, Route 1, Cumberland, X2				d. STREET ADDRESS National Highway			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Cumberland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Emma Middle G. Last Long		4. DATE OF DEATH		Month May Day 6th , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26th, 1904	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Knoyer				14. MOTHER'S MAIDEN NAME Louisa Alexander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Bruce Long, Jr., La Vale, Route 1, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema. Acute dilatation of heart 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 by hypertension essential DUE TO (c) Chronic myocarditis							INTERVAL BETWEEN ONSET AND DEATH 24 hrs 7 yrs 7 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 , 19____, to May 6 , 19 57 , that I last saw the deceased alive on May 6 , 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph R. Everhart				ADDRESS (Street, city or town, state) Rt 1 Natl Hwy Cumberland and Md.			
PHYSICIAN'S NAME (Type) Dr. L. E. Everhart				DATE SIGNED 5/8-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR May 9, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D., Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12505

BUREAU V. S.

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04711

4746

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS West Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle Jane Last Mackey		4. DATE OF DEATH Month May Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Grindle		14. MOTHER'S MAIDEN NAME Janet Clauson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Mackey		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on May 22, 19 57 , and that death occurred at 4 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) LONACONING MD DATE SIGNED 5-23-57			
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.			
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5.25/57	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE 5-25-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. R.	

CERTIFICATE OF DEATH

Name of Deceased James Mackey		Sex Male		Age 37	
Date of Birth April 1, 1918		Place of Birth Lombard, Maryland		U.S.A.	
Residence at Time of Death Lombard, Maryland		Cause of Death Coronary Arteriosclerosis		Place of Death Lombard, Maryland	
Occupation Janet Chanon		Signature of Physician James Mackey		Signature of Registrar Janet Chanon	
Manner of Death Natural		Certified by James Mackey		Date May 31, 1957	

BUREAU V. 2

MAY 31 1957

RECEIVED

5-22-57

George Stokholm
Lombard, Md.
5-22-57

4747 CERTIFICATE OF DEATH

04712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>MANCUSO</u> Middle <u>MANCUSO</u> Last				4. DATE OF DEATH <u>May</u> Month <u>16</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Nick Mancuso</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-1776</u>		17. INFORMANT <u>James Bisigano</u>		Address <u>55 Ormand St., Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured descending Colon, GANGRENOUS</u> DUE TO (c) <u>Adeno Carcinoma Colon</u> - yew							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>576x</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 19, 1956</u> , to <u>MAY 16, 1957</u> , that I last saw the deceased alive on <u>MAY 16, 1956</u> , and that death occurred at <u>1134 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Dever</u>				M.D. <u>134 E Main</u>			
PHYSICIAN'S NAME (Type) <u>John C. Dever</u>				ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>5/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> ADDRESS <u>23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4702

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>X2 Roullet, (LaVale) Cash Valley Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Francis</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 8, 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Ret. Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip C. Martin</u>				14. MOTHER'S MARRIED NAME <u>Ruth Ellen Arnold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James B. Smith, Rt. 1, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1948</u> to <u>May 10, 1957</u> , that I last saw the deceased alive on <u>Dec 12, 1956</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				DATE SIGNED <u>May 10, 1957</u>			
PHYSICIAN'S NAME (Type) <u>H. V. Deming</u>				ADDRESS (Street, city or town, state) <u>240 North Center Street, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Catholic Cem. Cumberland, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D. Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. RACE [Illegible]		5. PLACE OF BIRTH [Illegible]		6. DATE OF BIRTH [Illegible]		7. PLACE OF DEATH [Illegible]		8. DATE OF DEATH [Illegible]	
9. OCCUPATION [Illegible]		10. MARITAL STATUS [Illegible]		11. CAUSE OF DEATH [Illegible]		12. MANNER OF DEATH [Illegible]		13. MEDICAL HISTORY [Illegible]		14. HISTORY OF PRESENT ILLNESS [Illegible]		15. POST-MORTEM EXAMINATION [Illegible]		16. SIGNATURE OF PHYSICIAN [Illegible]	
17. SIGNATURE OF REGISTRAR [Illegible]		18. SIGNATURE OF WITNESS [Illegible]		19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. 3

MAY 15 1957

RECEIVED

31 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4703 CERTIFICATE OF DEATH

Reg. Dist. No. 04714

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Potomac St.				d. STREET ADDRESS 106 Potomac St.			
3. NAME OF DECEASED (Type or print) First John Bernard Middle Mc Hugh Last				4. DATE OF DEATH Month May Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer -retired				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Mc Hugh				14. MOTHER'S MAIDEN NAME Mary Conway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-12-6681		17. INFORMANT Mrs. John B. Mc Hugh, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sq. Cell Carcinoma 7 lower of Mouth 143x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to Mediastinum DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 2 1/4 years 6 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-30 , 19 55 , to 5-9 , 19 57 , that I last saw the deceased alive on 5-7 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Rhett Rathbone M.D.				DATE SIGNED 5/10/57			
PHYSICIAN'S NAME (Type) Dr. R. Rhett Rathbone, M.D. 122 S. Centre St., Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR May 11, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, Md. Acting Registrar	

MEDICAL CERTIFICATION

Page 31 Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 31 Within corporate limits

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 6

4748

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN TB 7Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43				d. STREET ADDRESS 325 Spruce 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 325 Spruce				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle Elbert Last Michael				4. DATE OF DEATH Month May Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 18. 1883	
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jesse Michael				14. MOTHER'S MAIDEN NAME Eliza Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Esther Uhl-Westernport, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis and Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 Years 5 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 10 , 1954, to May 23 , 1957, that I last saw the deceased alive on May 23 , 1957, and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul R. Wilson				ADDRESS (Street, city or town, state) Piedmont, N.C.			
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.				DATE SIGNED 5-23-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/57		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. B. B.				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 5-27-57	
				24b. REGISTRAR'S SIGNATURE Jean C. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED JAMES M. JONES		SEX Male		AGE 35		DATE OF BIRTH Jan 2, 1902		PLACE OF BIRTH Baltimore, Md.		RACE White		RELIGION Methodist		MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman		MILITARY SERVICE None		PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		DATE OF DEATH May 29, 1957		PLACE OF DEATH Home		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None		SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	
NAME OF DECEASED JAMES M. JONES		SEX Male		AGE 35		DATE OF BIRTH Jan 2, 1902		PLACE OF BIRTH Baltimore, Md.		RACE White		RELIGION Methodist		MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman		MILITARY SERVICE None		PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		DATE OF DEATH May 29, 1957		PLACE OF DEATH Home		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None		SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	

BUREAU V. 2

MAY 29 1957

RECEIVED

1
This is a duplicate of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on May 29, 1957.
The original certificate of death is on file in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on May 29, 1957.
The original certificate of death is on file in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on May 29, 1957.

CERTIFICATE OF DEATH

Reg. Dist. No.

4749

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS R.D. #1, Box 76			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last MILLER				4. DATE OF DEATH Month 5 Day 15 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1889	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Pekin, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Scott Miller				14. MOTHER'S MAIDEN NAME Margaret Muir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. War I				16. SOCIAL SECURITY NO. 220-10-2647		17. INFORMANT Address Frostburg, Md Mrs. Margaret Miller, R.D. 1, Box 76,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mo several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1955 , 19 55 , to May 15 , 19 57 , that I last saw the deceased alive on May 15 , 19 57 , and that death occurred of 1:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. Lane M.D.				ADDRESS (Street, city or town, state) Frostburg DATE SIGNED 5-15-57			
PHYSICIAN'S NAME (Type) W. M. Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Winter ADDRESS Hafer Funeral Home 75 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR 5-18-57		24b. REGISTRAR'S SIGNATURE Wm. H. H. R.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4704 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>26 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>923 Glenwood Street</u>				STREET ADDRESS (If rural give location) <u>923 Glenwood Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles Joseph Moore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 25 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 23, 1931</u>	9. AGE last birthday <u>26</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Margaret A. Mc Culley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. James P. Moore, Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>493X</u> IMMEDIATE CAUSE (A) <u>Pneumonia - Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>1) Mental Retardation</u>							
<u>2) Kyphosis</u>							
<u>3) Pneum chest 758.6</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u>, 19 <u>54</u>, to <u>May</u>, 19 <u>57</u>, that I last saw the deceased alive on <u>May 25</u>, 19 <u>57</u>, and that death occurred at <u>3:00 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>St. Quentin Rimmick</u>		DATE THEREOF <u>5-28-1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>May 27, 1957</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
		REGISTRAR'S SIGNATURE <u>W. Ben Cameron, M.D.</u>					
		Acting Registrar					

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		04718	
DR. REITER		Reg. Dist. No.	
4705		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY Hardy	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 85X 3	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last MYERS		4. DATE OF DEATH Month MAY Day 14 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1957
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (In years last birthday) 3 IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mineral County, West Virginia	
13. FATHER'S NAME CLARENCE E. MYERS		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME MARGARET L. BARB		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 9 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1957 , to May 14, 1957 , that I last saw the deceased alive on May 13, 1957 , and that death occurred at 12:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 112 Bedford St. Cumberland Md May 14, 1957 DATE SIGNED			
ACTUAL SIGNATURE Ralph A. Reiter		M.D. 112 Bedford St. Cumberland Md May 14, 1957	
PHYSICIAN'S NAME (Type) DR. RALPH A REITER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-57	
22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Old Fields W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank B. Thruv		ADDRESS Moorefield W. Va.	
24a. REC'D BY REGISTRAR May 18, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

1. **INSTRUCTIONS**
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04719

Reg. Dist. No. 4

4796

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>	<u>9 days</u>	TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>		STREET ADDRESS (If rural give location) <u>721 N. Mechanic St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Veronica</u> <u>Narey</u>		<u>5</u> / <u>9</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/8/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy C Cullen</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Donahue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Pt's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) <u>Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastatic Carcinoma lungs</u>		<u>7 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Leukemia Bone + (Rt)</u>		<u>4 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 9, 1957</u>, to <u>May 9, 1957</u>, that I last saw the deceased alive on <u>May 9, 1957</u>, and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Leo H. Long Jr. M.D.</u>		ADDRESS (Street, city, town, state) <u>456 N. Centre St. Frostburg, Maryland.</u>	
DATE <u>May 13, 1957</u>		DATE SIGNED <u>5/13/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>	
24. REC'D BY REGISTRAR <u>May 13, 1957</u>		LOCATION (City, town, or county) <u>Frostburg, Maryland.</u>	
REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home, Frostburg, Maryland.</u>	
DATE <u>May 13, 1957</u>		ADDRESS	

CERTIFICATE OF DEATH

WOMEN'S DEPT. NO.

NO. OF DEATHS IN THIS DISTRICT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RETURN

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

BUREAU V. 4
MAY 15 1957

RECEIVED

120013000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04720

4797

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 600 LOUISIANA AVE.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last PARKER		4. DATE OF DEATH Month MAY Day 29 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 12, 1896
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM PARKER		14. MOTHER'S MAIDEN NAME MAY NORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705 09 6693	
17. INFORMANT Mrs. Virginia Parker		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 27, 1957 , to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 9:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Union St Cumberland, Md. DATE SIGNED _____			
ACTUAL SIGNATURE George M. Simon M.D.		PHYSICIAN'S NAME (Type) GEORGE M. SIMONS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/1957	
22c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		22d. LOCATION (City, town, or county) (State) Romney, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24a. REC'D BY REGISTRAR May 31, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

4708

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILTON Middle J. Last PHILLIPS				4. DATE OF DEATH Month MAY Day 17 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 8, 1872	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher				10b. KIND OF BUSINESS OR INDUSTRY TEACHER			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES PHILLIPS				14. MOTHER'S MAIDEN NAME LUCY JENKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493x Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Pneumonia - Left lung DUE TO (c) 5 days				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Hypertension + Arteriosclerotic Heart Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-12 , 19 57 , to 5-17 , 19 57 , that I last saw the deceased alive on 5-16 , 19 57 , and that death occurred at 8:21 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William P. James M.D.				ADDRESS (Street, city or town, state) 4414 Centre St. Cumberland Md.			
DATE SIGNED 5-17-57				DATE SIGNED			
PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES				PHYSICIAN'S NAME (Type) Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
22d. LOCATION (City, town, or county) (State) Wilkesburg Penna.				22e. LOCATION (City, town, or county) (State) Wilkesburg Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Steinbock				ADDRESS Cum. Md.		24a. REC'D BY REGISTRAR May 18, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.				24c. REGISTRAR'S SIGNATURE Acting Registrar			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

SUBJECT

DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

AGE

SEX

PLACE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

1

2

DATE OF BIRTH

AGE

SEX

1

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

BUREAU V. 4
JUN 22 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 9

4750

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle G. Last PORTER				4. DATE OF DEATH Month May Day 17 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired conductor				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles W. Porter				14. MOTHER'S MAIDEN NAME Margaret Beal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW 1				16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Fannie Porter, Eckhart, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation Signed into Bladder 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probably Carcinoma Signed Colon DUE TO (c) 4 days 4 mo						INTERVAL BETWEEN ONSET AND DEATH 4 days 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 12, 1957 , to May 17, 1957 , that I lost sown the deceased olive on May 16, 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED May 17, 1957							
ACTUAL SIGNATURE Worm Lane M.D.				PHYSICIAN'S NAME (Type) Worm Lane MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-57		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 5-17-57				24b. REGISTRAR'S SIGNATURE Wm. Stanley N. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

4799 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
c. LENGTH OF STAY IN 1b 8/9/54		d. STREET ADDRESS 72 College Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle Price Last Price		4. DATE OF DEATH Month May Day 20 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 57	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Alfred Cline	
14. MOTHER'S MAIDEN NAME Mary Dudley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422:2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X Secondary aneurysm			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/9/54 , 19____, to 5/20/57 , 19____, that I last saw the deceased alive on 5/20/57 , 19____, and that death occurred at 4:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/20/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M. D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.		24a. REC'D BY REGISTRAR May 21, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased ALFRED J. ALFORD		Date of Death 1957	
Place of Birth ALFORD, ALABAMA		Date of Birth 1910	
Usual Residence 12 College Avenue ALFORD, ALABAMA		Date of Death 1957	
Sex Male		Race White	
Cause of Death (To be filled in by physician) 1. _____ 2. _____ 3. _____		Date of Death 1957	
Signature of Physician _____ M.D.		Signature of Registrar _____ Registrar	
Signature of Coroner _____ Coroner		Signature of Medical Examiner _____ Medical Examiner	

BUREAU V. 4

1957

RECEIVED

4710

CERTIFICATE OF DEATH

04724

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 Offutt Street</u>		d. STREET ADDRESS <u>107 Offutt St.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>W. A.</u> Middle <u>Rankin</u> Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O R R</u>	
11. BIRTHPLACE (State or foreign country) <u>Round Bottom W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Anna Litton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. John Rankin</u> Address <u>Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Haemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO <u>3 yrs</u> (c) <u>Arteriosclerosis</u> DUE TO <u>5 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>May 30, 1957</u> that I last saw the deceased alive on <u>May 29, 1957</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.		ADDRESS (Street, city or town, state) <u>236 W. 1st Cumberland Md.</u> DATE SIGNED <u>5/31/57</u>	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 1, 1957</u>	<u>Rose Hill Cem.</u>	<u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumberland Md.</u>	24a. REC'D BY REGISTRAR <u>June 1, 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u>	<u>Acting Registrar</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4758

CERTIFICATE OF DEATH

Reg. Dist. No. 04725 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6, Potomac Park		d. STREET ADDRESS 429 Fayette St.	
3. NAME OF DECEASED (Type or print) LOUISA A. READ		4. DATE OF DEATH Month May Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1862
9. AGE (In years last birthday) 94 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Kuhn		14. MOTHER'S MAIDEN NAME Katherine Bill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Read,		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vas- 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 , 19 57 , to 5/26 , 19 57 , that I last saw the deceased alive on 5/21 , 19 57 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		DATE SIGNED 5/27/57	
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		ADDRESS (Street, city or town, state) 420 N. Centre St. Cumberland Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24a. REC'D BY REGISTRAR May 28, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

4711 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 3/13/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jeremiah Middle H. F. Last Reynolds				4. DATE OF DEATH Month May Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Western Maryland R. R.				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Reynolds				14. MOTHER'S MAIDEN NAME Annie Ott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) Yes (If yes, give war or dates of service) Spanish Am.				16. SOCIAL SECURITY NO.			
17. INFORMANT P.O.Box 599 Address Cumberland, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) General Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 592x Chronic Nephritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 3/13/57 , 19____, to 5/27/57 , 19____, that I last saw the deceased alive on 5/27/57 , 19____, and that death occurred at 6:45 P. M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE James E. McLean M.D.				49 Greene St. 5/28/57			
PHYSICIAN'S NAME (Type)				Dr. James E. McLean, M. D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Allen, Inc.				ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR May 29, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
JAMES A. McLENNAN		37		Male		White		3/23/57		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Date of Birth		Place of Birth	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		3/23/57		Baltimore, Maryland	
Occupation		Education		Marital Status		Previous Illnesses		Date of Admission		Date of Discharge	
None		High School		Married		None		3/23/57		3/23/57	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Date of Burial		Date of Cremation		Date of Interment		Date of Exhumation		Date of Reinterment	
3/23/57		3/23/57		None		3/23/57		None		None	
Place of Burial		Place of Cremation		Place of Interment		Place of Exhumation		Place of Reinterment		Place of Disposition	
Baltimore, Maryland		None		Baltimore, Maryland		None		None		None	
Funeral Home		Crematorium		Interment		Exhumation		Reinterment		Disposition	
None		None		Baltimore, Maryland		None		None		None	
Funeral Director		Crematorium Director		Interment Director		Exhumation Director		Reinterment Director		Disposition Director	
None		None		Baltimore, Maryland		None		None		None	
Date of Death		Date of Burial		Date of Cremation		Date of Interment		Date of Exhumation		Date of Reinterment	
3/23/57		3/23/57		None		3/23/57		None		None	
Place of Burial		Place of Cremation		Place of Interment		Place of Exhumation		Place of Reinterment		Place of Disposition	
Baltimore, Maryland		None		Baltimore, Maryland		None		None		None	
Funeral Home		Crematorium		Interment		Exhumation		Reinterment		Disposition	
None		None		Baltimore, Maryland		None		None		None	
Funeral Director		Crematorium Director		Interment Director		Exhumation Director		Reinterment Director		Disposition Director	
None		None		Baltimore, Maryland		None		None		None	

RECEIVED
MAY 31 1957
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

4

4712

1. PLACE OF DEATH o. COUNTY <u>Alleghany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Alleghany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>407 Grand Avenue</u>				d. STREET ADDRESS <u>407 Grand Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Frances</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1869</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>		IF UNDER 24 HRS. Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Glendale, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>Silas Walters</u>				14. MOTHER'S MAIDEN NAME <u>Martha Harvey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Mae Winters</u>				Address <u>407 Grande Ave. Cumber-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis</u> DUE TO (c) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u> <u>7 day</u> <u>5 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334 X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Swanton, Md.</u>				(County) (State)			
21. I certify that I attended the deceased from <u>May 1, 1957</u> , to <u>May 17, 1957</u> , that I last saw the deceased alive on <u>May 17, 1957</u> , and that death occurred at <u>Swanton, Md.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clay E. Durrett</u>				ADDRESS (Street, city or town, state) <u>236 24th, Can Cumberland</u>			
DATE SIGNED <u>5/20/57</u>							
PHYSICIAN'S NAME (Type) <u>CLAY E. DURRETT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill, North Glade</u>		22d. LOCATION (City, town, or county) (State) <u>near Swanton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Ross</u> Bolden Funeral Home <u>oakland, Md.</u>				24a. REC'D BY REGISTRAR <u>May 24, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Ross, America, Md.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04728

4759

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Flintstone		c. LENGTH OF STAY IN 1b 83yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES CLARIDON RICE		4. DATE OF DEATH Month May Day 26 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-1873
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Allegany Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Marion Rice		14. MOTHER'S MAIDEN NAME Maria Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Humbird Rice		Address RT.#2 Flintstone, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 537X Uremia DUE TO Paratititis - left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 wk DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 19 57 to May 26, 19 57 , that I last saw the deceased alive on May 24, 19 57 , and that death occurred at 3:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED 5/27/57	
ACTUAL SIGNATURE W. R. Hodges		M.D. 122 So. Centre St.,	
PHYSICIAN'S NAME (Type) W. R. Hodges M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5- 28- 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		22d. LOCATION (City, town, or county) (State) Near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES L. GEORGE		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 28, 1957		24b. REGISTRAR'S SIGNATURE Hina L. Bender	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Date of Birth		Place of Birth	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		Time of Registration		Place of Registration	

BUREAU V. S.

JUN 5 1957

RECEIVED

047294

Within corporate limits

DR. VAN ORMER

4713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 62 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle H. Last ROBINETTE				4. DATE OF DEATH Month MAY Day 31 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 31, 1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) CORRIGANSVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ROBINETTE				14. MOTHER'S MAIDEN NAME BESSIE KLINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-2971		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colloidal disease, ill-defined and 456x DUE TO type undet. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12 noon , 19 57 , to 31 May , 19 57 , that I last saw the deceased alive on 31 May , 19 57 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/3/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Savage Meth. Cemetery Mt. Savage, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR June 3, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 5 1957

RECEIVED

4711 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
e. STREET ADDRESS 333 Brett Street							
3. NAME OF DECEASED (Type or print) First Caroline Middle Rodriguez Last Rodriguez				4. DATE OF DEATH Month 5 Day 18 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife, Own Home		11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francisco Campa				14. MOTHER'S MAIDEN NAME Maria Cuervo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 3 mos 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-15 , 19 57 , to 5-18 , 19 57 , that I last saw the deceased alive on 5-18 , 19 57 , and that death occurred at 6:50 a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ralph W. Ballin, M.D. 62 Greene St. 5-18-57 Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF May 20, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Peter's Catholic Cem.		22d. LOCATION (City, town, or county) (State) Westernport, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Boal's Funeral Home, Westernport, Maryland.							
24a. REC'D BY REGISTRAR May 20, 1957				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death.

BUREAU V. 31

1957

RECEIVED

4715

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 yr. 7 mo. 15 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat Furnace st.			d. STREET ADDRESS 346 Dorn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle R. Last Rowe			4. DATE OF DEATH Month 5 Day 25 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1877		9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Tire Industry		11. BIRTHPLACE (State or foreign country) Harpers Ferry, W.Va.	
13. FATHER'S NAME Samuel Rowe			14. MOTHER'S MAIDEN NAME Emma Warnsfelt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-1035		17. INFORMANT Address Harvey G. Rowe, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) General Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 36 hrs ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angitis obliterans & Gangrene					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 453.1		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 453.1			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 9, 1958 to May 23, 1957 , that I last saw the deceased alive on May 23, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE James E. McLean, M.D.				ADDRESS (Street, city or town, State) 49 Greene	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.				DATE SIGNED 5/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-57		22c. NAME OF CEMETERY OR CREMATORY Ss. Peter & Paul	
22d. LOCATION (City, town, or county) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			24a. REC'D BY REGISTRAR May 27, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 29 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M d. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 51 Elder St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle C. Last Rowe				4. DATE OF DEATH Month May Day 16 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27-1882		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Church Sexton		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Rowe				14. MOTHER'S MAIDEN NAME Anna M. Athey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT (sister) Nellie Painter, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (apoplexy) about 7 hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 16-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.				24a. REC'D BY REGISTRAR May 17, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 4

1957

RECEIVED

4717 CERTIFICATE OF DEATH

Reg. Dist. No.

04733

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Arundel St.,		d. STREET ADDRESS 707 Arundel St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle LE ROY Last SCARLETT		4. DATE OF DEATH Month May Day 20th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1902
9. AGE (In years lost birthday) yrs. 55		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch Inspector		10b. KIND OF BUSINESS OR INDUSTRY Jewelry	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Richard Scarlett		14. MOTHER'S MAIDEN NAME Sarah Shewbridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Lena Scarlett		Address 707 Arundel St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Breast DUE TO (c) Breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Breast INTERVAL BETWEEN ONSET AND DEATH Breast			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20/56 , 19____, to 5/20/57 , 19____, that I last saw the deceased alive on 5/20/57 , 19____, and that death occurred at 4:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED May 21, 1957			
ACTUAL SIGNATURE Richard J. Williams M. D.		M.D. 122 So. Centre St.,	
PHYSICIAN'S NAME (Type) Richard J. Williams M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/57	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 21, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Place of Registration	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Burial Place		17. Date of Burial		18. Signature of Burial Place	
19. Name of Undertaker		20. Address of Undertaker		21. Signature of Undertaker	
22. Name of Coroner		23. Address of Coroner		24. Signature of Coroner	
25. Name of Medical Examiner		26. Address of Medical Examiner		27. Signature of Medical Examiner	
28. Name of Health Officer		29. Address of Health Officer		30. Signature of Health Officer	
31. Name of Registrar		32. Address of Registrar		33. Signature of Registrar	
34. Name of Clerk		35. Address of Clerk		36. Signature of Clerk	
37. Name of Assistant Clerk		38. Address of Assistant Clerk		39. Signature of Assistant Clerk	
40. Name of Deputy Clerk		41. Address of Deputy Clerk		42. Signature of Deputy Clerk	
43. Name of Secretary		44. Address of Secretary		45. Signature of Secretary	
46. Name of Assistant Secretary		47. Address of Assistant Secretary		48. Signature of Assistant Secretary	
49. Name of Deputy Secretary		50. Address of Deputy Secretary		51. Signature of Deputy Secretary	
52. Name of Chief Clerk		53. Address of Chief Clerk		54. Signature of Chief Clerk	
55. Name of Assistant Chief Clerk		56. Address of Assistant Chief Clerk		57. Signature of Assistant Chief Clerk	
58. Name of Deputy Chief Clerk		59. Address of Deputy Chief Clerk		60. Signature of Deputy Chief Clerk	
61. Name of Secretary		62. Address of Secretary		63. Signature of Secretary	
64. Name of Assistant Secretary		65. Address of Assistant Secretary		66. Signature of Assistant Secretary	
67. Name of Deputy Secretary		68. Address of Deputy Secretary		69. Signature of Deputy Secretary	
70. Name of Chief Clerk		71. Address of Chief Clerk		72. Signature of Chief Clerk	
73. Name of Assistant Chief Clerk		74. Address of Assistant Chief Clerk		75. Signature of Assistant Chief Clerk	
76. Name of Deputy Chief Clerk		77. Address of Deputy Chief Clerk		78. Signature of Deputy Chief Clerk	
79. Name of Secretary		80. Address of Secretary		81. Signature of Secretary	
82. Name of Assistant Secretary		83. Address of Assistant Secretary		84. Signature of Assistant Secretary	
85. Name of Deputy Secretary		86. Address of Deputy Secretary		87. Signature of Deputy Secretary	
88. Name of Chief Clerk		89. Address of Chief Clerk		90. Signature of Chief Clerk	
91. Name of Assistant Chief Clerk		92. Address of Assistant Chief Clerk		93. Signature of Assistant Chief Clerk	
94. Name of Deputy Chief Clerk		95. Address of Deputy Chief Clerk		96. Signature of Deputy Chief Clerk	
97. Name of Secretary		98. Address of Secretary		99. Signature of Secretary	
100. Name of Assistant Secretary		101. Address of Assistant Secretary		102. Signature of Assistant Secretary	

BUREAU V. 31

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04734

Within corporate limits

4718

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1400 Virginia Ave</u>				d. STREET ADDRESS <u>11400 Virginia Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>C.</u> Last <u>Shanboltz</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1871</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Augusta W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Choise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Hilda Ryan</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Strainia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Haemorrhage</u> DUE TO <u></u> (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>14 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>57</u> , to <u>May 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>57</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.				ADDRESS (Street, city or town, state) <u>23624, Cumb. Md.</u>			
DATE SIGNED <u>5/20/57</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 22, 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Augusta W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md.</u>			
24a. REC'D BY REGISTRAR <u>May 20, 1957</u>				24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
Blanche Brown		45		F		W		1880		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 Main St.		Housewife		Heart Disease		Natural		1957		Home	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE	
John Brown		Mary Brown		High School		Roman Catholic		Married		1900	
PREVIOUS DEATHS		DATE OF PREVIOUS DEATH		CAUSE OF PREVIOUS DEATH		MANNER OF PREVIOUS DEATH		DATE OF PREVIOUS DEATH		PLACE OF PREVIOUS DEATH	
None		None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1957		Home		Heart Disease		Natural		1957		Home	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE	
John Brown		Mary Brown		High School		Roman Catholic		Married		1900	

BUREAU V. 4

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04735

4719

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 S. Smallwood St</u>		d. STREET ADDRESS <u>18 S. Smallwood St</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth B. Shoupe</u>		4. DATE OF DEATH <u>May 16 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1881</u>
9. AGE (In years, last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>16</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Poncaconing Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank E. Brackett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Steele</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John Shoupe</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastases to lungs & nebrachium</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Left Breast</u> DUE TO (c) <u>6 yrs 5 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>51</u> , to <u>5/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/16/57</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>R. Rhett Rathbone</u>		M.D. _____	
PHYSICIAN'S NAME (Type) <u>Dr. R. Rhett Rathbone, M. D.</u>		<u>122 South Centre St. Cumberland, Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Mar. 18/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumb. Md.</u>	
24. REC'D BY REGISTRAR <u>May 18, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1957</i>		6. PLACE OF DEATH <i>Home</i>	
7. TIME OF DEATH <i>10:00 AM</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. 4

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4720

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 34 Roberts St., Cumberland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Simpson		4. DATE OF DEATH Month May Day 18 , Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1877
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Timber Worker		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Simpson		14. MOTHER'S MAIDEN NAME Mary Ann Cleek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 - 10 - 0601-A	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chronic Pyocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Chronic Prostatitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20/57 , 19 57 to 5/18/57 , 19 57 , that I last saw the deceased alive on 5/18/57 , 19 57 , and that death occurred at 5:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/20/57 ACTUAL SIGNATURE James E. McLean, M.D. PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Dawson Cemetery		22d. LOCATION (City, town, or county) (State) Dawson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer,		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 21, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, Md. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1 2 2 3 3

100-443887-100

1215

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04737

Reg. Dist. No.

4721

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Sacred Heart Hospital				d. STREET ADDRESS Route #3 Bowmans Addition			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Perry Last Smith				4. DATE OF DEATH Month May Day 11 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30-1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired- Cabinet maker				10b. KIND OF BUSINESS OR INDUSTRY Vulcanizer - Tire		11. BIRTHPLACE (State or foreign country) Flintstone, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Amos Robert Smith				14. MOTHER'S MAIDEN NAME Anna R. Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 348-14-7799		17. INFORMANT Address (sister) Sarah E. Smith, Flintstone, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (c) 420.1 DUE TO (c) 420.1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							INTERVAL BETWEEN ONSET AND DEATH sudden ?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 12-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Flintstone, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox, Cumberland, Maryland.				ADDRESS 		24a. REC'D BY REGISTRAR May 13, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

4722

CERTIFICATE OF DEATH

Reg. Dist. No.

04738

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 CUMBERLAND, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #3, BEDFORD ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALVERTIA ARDELLA STEIN		4. DATE OF DEATH Month Day Year MAY, 11, 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIDNEY CROSS		14. MOTHER'S MAIDEN NAME CATHERINE PRIDGON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. gone	
17. INFORMANT Mr. Harry Stein		Address Cumberland Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chl Myocarditis - Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus - Insulinated Unilateral Blind		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 57 , to 11 May , 19 57 , that I last saw the deceased alive on 11 May , 19 57 , and that death occurred at 6:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 21 May 57			
ACTUAL SIGNATURE Fuller B Whitworth M.D.			
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 14, 1957	Gion Memo Park	Cumberland, Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR May 13, 1957	
ADDRESS Cumberland Md		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, MD Acting Registrar	

1957 51 MAY

BUREAU V. 81

RECEIVED

DR. W. F. WILLIAMS 4723 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 23 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 817 WINDSOR ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CLARENCE Middle H. Last STEIN				4. DATE OF DEATH Month MAY Day 30 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 28, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT				10b. KIND OF BUSINESS OR INDUSTRY STEIN FUNERAL HOME		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LOUIS STEIN				14. MOTHER'S MAIDEN NAME FANNIE KOEGEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-4316		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardiovas. disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio sclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH Since Feb. 56			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 7:25, 1957 , to 5:30, 1957 , that I last saw the deceased alive on 5:39, 1957 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D. Cumberland Md				DATE SIGNED 5:31:57			
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		June 1, 1957		Rose Hill Mausoleum		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.		24. REC'D BY REGISTRAR June 1, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.				Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JOHN J. BURKE		45		M		W		JUN 3 1957		HOSPITAL	
RESIDENCE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
1234 MAIN ST.		JAN 1 1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS MARRIAGES		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		8		M		1		HEART DISEASE		NATURAL	
HISTORY OF ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
HEAVY COLD		JUN 1		JUN 3		JUN 3		CATHOLIC CHURCH		BOSTON	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE	
[Signature]		JUN 3 1957		[Signature]		JUN 3 1957		[Signature]		JUN 3 1957	

BURKE V. J.

JUN 5 1957

RECEIVED

4751 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN TB 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 23 Welsh St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GILBERT Middle N. Last THOMPSON				4. DATE OF DEATH Month May Day 10 , Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-17-1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Street dept.				10b. KIND OF BUSINESS OR INDUSTRY City of Frostburg			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James A. Thompson				14. MOTHER'S MAIDEN NAME Lucy Lafferty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 216-01-8830			
17. INFORMANT Mrs. Gilbert Thompson, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell sarcoma of lungs. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1956 , to May 10, 1957 , that I last saw the deceased alive on May 10, 1957 , and that death occurred at 9:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.E. Gattens				ADDRESS (Street, city or town, state) 167 E. Main St. Frostburg, Md.			
PHYSICIAN'S NAME (Type) W.E. Gattens				DATE SIGNED 5/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 5-13-57				24b. REGISTRAR'S SIGNATURE Wm. Stanley A. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04741**

1. PLACE OF DEATH a. COUNTY A llegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/8/57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 47 Oak Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Landonia Last Turner		4. DATE OF DEATH Month May Day 23 , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/1878
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Dailey		14. MOTHER'S MAIDEN NAME Mary Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) General arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 592x Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/8/57 , 19____, to 5/23/57 , 19____, that I last saw the deceased alive on 5/23/57 , 19____, and that death occurred at 4:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 5/24/57			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS 49 Greene Street DATE SIGNED 5/24/57	
PHYSICIAN'S NAME (Type) Dr. McLean, James E., M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-57	
22c. NAME OF CEMETERY OR CREMATORY Arnon Chapel		22d. LOCATION (City, town, or county) (State) Forestville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR May 27, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

CERTIFICATE OF DEATH

Name of Deceased		A. Hoggan	
Date of Birth		5/2/27	
Place of Birth		Gumbertland	
Residence at Time of Death		12 Oak Street	
Cause of Death		Tuberculosis	
Date of Death		May 29, 1957	
Place of Death		Home	
Sex		Male	
Race		White	
Marital Status		Married	
Spouse's Name		Margaret Hoggan	
Occupation		None	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		May 30, 1957	
Place of Registration		Baltimore, MD	

RECEIVED
MAY 29 1957
BUREAU Y. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W.Va. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta 85x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Wilbert F. Voit		4. DATE OF DEATH Month May Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31-1834
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman for the Potomac P. & L. Co.		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth Voit		14. MOTHER'S MAIDEN NAME Margaret P. Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 2 yrs. Service	
17. INFORMANT Memorial Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of brain DUE TO Intracranial hemorrhage (slight) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lineal fractures of skull (left) (auto accident) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) W.Va., Lost control of car, hit an embankment, thrown out. Rt. 50	
20c. TIME OF INJURY Month, Day, Year Hour 12.30 o. m. May 5 19 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt 50 near Romney		20f. (City or town) (County) (State) W.Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 7-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	22d. LOCATION (City, town, or county) (State) Slanesville, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Wade McKee, Augusta, West Virginia.		24a. REC'D BY REGISTRAR May 8, 1957	
		24b. REGISTRAR'S SIGNATURE Ed. Ross Cameron M.D. Acting Deputy State Health Officer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
EDUCATION		RELIGION		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POSTMORTEM EXAMINATION	
SIGNATURE OF EXAMINER		DATE		TIME		LOCATION		HOSPITAL	
OFFICIAL SEAL		STAMP		STAMP		STAMP		STAMP	

BUREAU V. 8

MAY 10 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 20 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 430 Virginia Ave		d. STREET ADDRESS 430 Virginia Ave.	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Ezra Last Wachter		4. DATE OF DEATH about May Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17-1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 57 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY B&O.Y.M.C.A.	11. BIRTHPLACE (State or foreign country) Eckhart, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Reverdy A. Wachter	
14. MOTHER'S MAIDEN NAME Elizabeth Hausrath		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. W.W.1 218-30-0016		17. INFORMANT (brother) George Wachter, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) ? (a), stating the underlying cause last, DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 9-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR May 11, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral. Page 3 should be used as a burial-transit permit. Page 4 should be used as a cremation permit. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

BUREAU V. B.

MAY 15 1957

RECEIVED

Within corporate limits

4727

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

219 So. Smallwood St.,

d. STREET ADDRESS

1 219 So. Smallwood St.,

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First

ALBERT

Middle

S.

Last

WALKER

4. DATE OF DEATH

Month

May

Day

21,

Year

1957

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

B. DATE OF BIRTH

Sept. 9, 1879

9. AGE (In years lost birthday)

77 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Ins. Agent

10b. KIND OF BUSINESS OR INDUSTRY

Peoples Life Ins.

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

George Walker

14. MOTHER'S MAIDEN NAME

Barbara Weigand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No,

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Grace M. Walker 219 S. Smallwood St., Cumb.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ca. of esophagus

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
9 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. s. p. m.

19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 12-29, 1957, to 5-21, 1957, that I last saw the deceased alive on 5-21, 1957, and that death occurred at 11 a. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Ralph W. Ballin

M.D.

62 Greene St.,

PHYSICIAN'S NAME (Type)

Ralph W. Ballin M. D.

Cumberland, Md.

5-22-57

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/24/57

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

May 24, 1957

W. Ross Cameron, M.D.
Acting Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 27 1957

4728

CERTIFICATE OF DEATH

Reg. Dist. No.

04745

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. STREET ADDRESS 407 WASHINGTON ST			
3. NAME OF DECEASED (Type or print) First MARY Middle G Last WEBER				4. DATE OF DEATH Month MAY Day 23 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1882		9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM WILEY				14. MOTHER'S MAIDEN NAME LILLIAN OGLEBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. W. Weber Address Pittsburgh Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-19-57 to 5-23-57 , that I last saw the deceased alive on 5-23-57 , and that death occurred at 7:26 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md		DATE SIGNED 5/23/57	
PHYSICIAN'S NAME (Type) W.F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md		24a. REC'D BY REGISTRAR May 25, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, Md.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. J.

MAY 29 1957

RECEIVED

4729

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 166 BEDFORD ST.,	
3. NAME OF DECEASED (Type or print) First BERTHA Middle WEISENMILLER Last WEISENMILLER		4. DATE OF DEATH Month MAY Day 6 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1885
9. AGE (In years lost birthday) yrs. 72		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED WEISENMILLER		14. MOTHER'S MAIDEN NAME Unknown, MATHEWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Malacia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of Liver DUE TO (c) 3 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 mos			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957 to May 6, 1957 , that I last saw the deceased alive on May 6, 1957 , and that death occurred at 9:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clayton J. Durrett		ADDRESS (Street, city or town, state) 736 W. Ave. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. DURRETT		DATE SIGNED 5/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 8, 1957	Woodsboro, Md.	Cumbr. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Steinberg		24a. REC'D BY REGISTRAR May 8, 1957	
ADDRESS Cumbr. Md.		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	
		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35		4. DATE OF DEATH MAY 2 1968	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION CONTRACTOR		7. MARITAL STATUS MARRIED		8. CAUSE OF DEATH HEART DISEASE	
9. PLACE OF DEATH MEMPHIS, TENNESSEE		10. TIME OF DEATH 10:00 AM		11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESS (None)	
13. NAME OF PHYSICIAN DR. J. H. HARRIS		14. NAME OF HOSPITAL MEMPHIS HOSPITAL		15. NAME OF COUNTY SHELBY COUNTY		16. NAME OF CITY MEMPHIS	
17. NAME OF STATE TENNESSEE		18. NAME OF COUNTY SHELBY COUNTY		19. NAME OF CITY MEMPHIS		20. NAME OF ZIP CODE 38103	
21. NAME OF DECEASED JAMES EARL RAY		22. NAME OF DECEASED JAMES EARL RAY		23. NAME OF DECEASED JAMES EARL RAY		24. NAME OF DECEASED JAMES EARL RAY	
25. NAME OF DECEASED JAMES EARL RAY		26. NAME OF DECEASED JAMES EARL RAY		27. NAME OF DECEASED JAMES EARL RAY		28. NAME OF DECEASED JAMES EARL RAY	
29. NAME OF DECEASED JAMES EARL RAY		30. NAME OF DECEASED JAMES EARL RAY		31. NAME OF DECEASED JAMES EARL RAY		32. NAME OF DECEASED JAMES EARL RAY	
33. NAME OF DECEASED JAMES EARL RAY		34. NAME OF DECEASED JAMES EARL RAY		35. NAME OF DECEASED JAMES EARL RAY		36. NAME OF DECEASED JAMES EARL RAY	
37. NAME OF DECEASED JAMES EARL RAY		38. NAME OF DECEASED JAMES EARL RAY		39. NAME OF DECEASED JAMES EARL RAY		40. NAME OF DECEASED JAMES EARL RAY	
41. NAME OF DECEASED JAMES EARL RAY		42. NAME OF DECEASED JAMES EARL RAY		43. NAME OF DECEASED JAMES EARL RAY		44. NAME OF DECEASED JAMES EARL RAY	
45. NAME OF DECEASED JAMES EARL RAY		46. NAME OF DECEASED JAMES EARL RAY		47. NAME OF DECEASED JAMES EARL RAY		48. NAME OF DECEASED JAMES EARL RAY	
49. NAME OF DECEASED JAMES EARL RAY		50. NAME OF DECEASED JAMES EARL RAY		51. NAME OF DECEASED JAMES EARL RAY		52. NAME OF DECEASED JAMES EARL RAY	
53. NAME OF DECEASED JAMES EARL RAY		54. NAME OF DECEASED JAMES EARL RAY		55. NAME OF DECEASED JAMES EARL RAY		56. NAME OF DECEASED JAMES EARL RAY	
57. NAME OF DECEASED JAMES EARL RAY		58. NAME OF DECEASED JAMES EARL RAY		59. NAME OF DECEASED JAMES EARL RAY		60. NAME OF DECEASED JAMES EARL RAY	
61. NAME OF DECEASED JAMES EARL RAY		62. NAME OF DECEASED JAMES EARL RAY		63. NAME OF DECEASED JAMES EARL RAY		64. NAME OF DECEASED JAMES EARL RAY	
65. NAME OF DECEASED JAMES EARL RAY		66. NAME OF DECEASED JAMES EARL RAY		67. NAME OF DECEASED JAMES EARL RAY		68. NAME OF DECEASED JAMES EARL RAY	
69. NAME OF DECEASED JAMES EARL RAY		70. NAME OF DECEASED JAMES EARL RAY		71. NAME OF DECEASED JAMES EARL RAY		72. NAME OF DECEASED JAMES EARL RAY	
73. NAME OF DECEASED JAMES EARL RAY		74. NAME OF DECEASED JAMES EARL RAY		75. NAME OF DECEASED JAMES EARL RAY		76. NAME OF DECEASED JAMES EARL RAY	
77. NAME OF DECEASED JAMES EARL RAY		78. NAME OF DECEASED JAMES EARL RAY		79. NAME OF DECEASED JAMES EARL RAY		80. NAME OF DECEASED JAMES EARL RAY	
81. NAME OF DECEASED JAMES EARL RAY		82. NAME OF DECEASED JAMES EARL RAY		83. NAME OF DECEASED JAMES EARL RAY		84. NAME OF DECEASED JAMES EARL RAY	
85. NAME OF DECEASED JAMES EARL RAY		86. NAME OF DECEASED JAMES EARL RAY		87. NAME OF DECEASED JAMES EARL RAY		88. NAME OF DECEASED JAMES EARL RAY	
89. NAME OF DECEASED JAMES EARL RAY		90. NAME OF DECEASED JAMES EARL RAY		91. NAME OF DECEASED JAMES EARL RAY		92. NAME OF DECEASED JAMES EARL RAY	
93. NAME OF DECEASED JAMES EARL RAY		94. NAME OF DECEASED JAMES EARL RAY		95. NAME OF DECEASED JAMES EARL RAY		96. NAME OF DECEASED JAMES EARL RAY	
97. NAME OF DECEASED JAMES EARL RAY		98. NAME OF DECEASED JAMES EARL RAY		99. NAME OF DECEASED JAMES EARL RAY		100. NAME OF DECEASED JAMES EARL RAY	

RECEIVED
MAY 10 1968
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04747

Within corporate limits.

4730

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1 549 FAIRVIEW AVE.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last JESSE EPHRAIM WELSH				4. DATE OF DEATH Month Day Year MAY 19 19 57.					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 3, 1879		9. AGE (In years last birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Service Station Attendant				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN C. WELSH				14. MOTHER'S MAIDEN NAME ALICE LEDGWEGH Ludwige					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-24-8778		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-2, 1955, to 5-19, 1957, that I last saw the deceased alive on 5-19, 1957, and that death occurred at 10:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ralph W. Ballin M.D. 62 Greene St. 5-20-57 PHYSICIAN'S NAME (Type) DR. RALPH W. BALLIN Cumberland, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/57		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Leesilcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 21, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

BUREAU V. M.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WHITWORTH

4731

CERTIFICATE OF DEATH

Reg. Dist. No.

04748

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1 25 WEMPE DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WHEELER, Middle BABY BOY #1 Last		4. DATE OF DEATH Month MAY Day 9 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1957
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JULIAN R. WHEELER		14. MOTHER'S MAIDEN NAME ALICE F. FITZWATER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity 5 mo DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. F.B. Whitworth M.D.			
PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF May 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital		23a. REC'D BY REGISTRAR May 10, 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04749

DR. WHITWORTH

4732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 9 HRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1 25 WEMPE DRIVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WHEELER Middle BABY Last BOY #2		4. DATE OF DEATH Month MAY Day 9 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1957
9. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JULIAN R. WHEELER		14. MOTHER'S MAIDEN NAME ALICE F. FITZWATER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurely 5 mo DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Julius B. Whitworth M.D.			
PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF May 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital		ADDRESS	24a. REC'D BY REGISTRAR May 10, 1957
			24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar

82745713 3 2016

STEWART, R. A. 1991.

CONFIDENTIAL - INTERNAL USE ONLY

BUREAU V. S.

MAY 14 1957

RECEIVED

4733

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CUMBERLAND, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY First WIEGAND Last				4. DATE OF DEATH Month MAY Day 19 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tinsmith				10b. KIND OF BUSINESS OR INDUSTRY Tinshop		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME HENRY WIEGAND			
14. MOTHER'S MAIDEN NAME KATHERINE - Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT 6221 Magnolia, Drive Emily Smith W. Hollywood, Fla.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 5-13 , 19 57 , to 5-19 , 19 57 , that I last saw the deceased alive on 5-19 , 19 57 , and that death occurred at 6:12 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 62 Greene St. 5-20-57							
ACTUAL SIGNATURE Ralph W. Ballin M.D. 62 Greene St. 5-20-57							
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/24/57	22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox			ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 23, 1957		
					24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04751

Reg. Dist. No.

4734

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany Co. Sylvan Retreat		d. STREET ADDRESS 201 Fayette St.	

3. NAME OF DECEASED (Type or print) First Arch Middle C. Last Willison		4. DATE OF DEATH Month May Day 15 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7-1864
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Supt. of schools,	10b. KIND OF BUSINESS OR INDUSTRY Allegany Co. Md.	11. BIRTHPLACE (State or foreign country) Flintstone, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Hanson Willison	14. MOTHER'S MAIDEN NAME Lillian Smith
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT (daughter) Dorothy Willison, Cumberland, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hypostasis 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 days ?
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left femur at the surgical neck.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 903.7	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Feeble, walking to bathroom & fell to the floor.		
20c. TIME OF INJURY Month, Day, Year 4-15-57 May 11 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sylvan Retreat Cumberland Allegany Md.	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE H. V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) H. V. Deming M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	May 16-1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.	ADDRESS	24a. REC'D BY REGISTRAR May 17, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

BUREAU OF HEALTH

APR 30 1957

RECEIVED

Within corporate limits

4735
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 816. Greene Street		d. STREET ADDRESS 816. Greene Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Twila Middle Othelia Last Willison		4. DATE OF DEATH Month May Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1896
9. AGE (In years and birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Acct Office		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR.	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles C. Willison		14. MOTHER'S MAIDEN NAME Alice Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-8179	
17. INFORMANT Miss Mildred Willison		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestines (colon) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos. 6 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 28 , 1957, to May 10 , 1957, that I last saw the deceased alive on May 10 , 1957, and that death occurred at 6:40 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Zimmermann		ADDRESS (Street, city or town, state) 105 S. Centre St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) C. C. Zimmermann, M.D.		DATE SIGNED 5-11-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 13 1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 13, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Alfred		Sex Male	
Age 83 Years		Date of Death May 21 1957	
Place of Birth St. George Street		Place of Death St. George Street	
Cause of Death Chronic		Manner of Death Chronic	
Signature of Physician Charles C. Wilson		Signature of Registrar Alfred	
Date of Death May 21 1957		Time of Death 10:30 A.M.	
Place of Death St. George Street		City St. George	
County St. George		State U.S.A.	

BUREAU V. 2

MAY 15 1957

RECEIVED

May 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04753

4736

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle WILSON Last WILSON		4. DATE OF DEATH Month MAY Day 9 Year 1957		
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wilson, Donald Albert		14. MOTHER'S MAIDEN NAME BROWN, EUNICE ELLEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT MEMORIAL HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Replaced Keubus 4 mo (c) None				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumt Md DATE SIGNED DR WHITWORTH				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE DR WHITWORTH		24a. REC'D BY REGISTRAR DR WHITWORTH		
24b. REGISTRAR'S SIGNATURE DR WHITWORTH		24c. DATE May 10, 1957		

BUREAU A. 3

MAY 14 1957

RECEIVED

4752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 W. Main St.		d. STREET ADDRESS 128 W. Main St.	
3. NAME OF DECEASED (Type or print) First HARRY Middle E. Last WITT		4. DATE OF DEATH Month MAY Day 5 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1886
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas station attendant F'bg. Auto Co.		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Witt		14. MOTHER'S MAIDEN NAME Alice Moser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-8841	
17. INFORMANT Mrs. Harry Witt, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs - 2 yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 178X Carcinoma testicles c metastasis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 19 56 , to May 5, 19 57 , that I last saw the deceased alive on May 5 , 19 57 , and that death occurred at 140A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md. DATE, SIGNED 5/6/57			
ACTUAL SIGNATURE John B. Davis, M.D.		DATE, SIGNED 5/6/57	
PHYSICIAN'S NAME (Type) John B. Davis, M. D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-8-57	22c. NAME OF CEMETERY OR CREMATORY Cooks Cemetery	22d. LOCATION (City, town, or county) (State) Wellersburg, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 5-8-57	
		24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

